

NAME: _____

RECORD #: _____

_____’s Plan

Plan Meeting Date: _____

For Plan Approver Only

Plan Approved By: _____

Plan Approved Date: ____ / ____ / ____

Name (As appears on Medicaid Card)	Preferred Name
LME	Case Manager
Agency/Provider Name:	
Record Number	Date of Birth
Address	Phone
City, State, Zip	Medicaid County
Social Security Number	Medicaid ID#:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Medicare/Insurance
Race/Ethnicity: White__ African Am__ Hispanic__ Native Am__ Asian__ Other__	

TYPE <input type="checkbox"/> Initial Plan <input type="checkbox"/> CNR CAP-MR/DD <input type="checkbox"/> At Risk for ICF/MR Placement <input type="checkbox"/> Previously in an ICF-MR bed <input type="checkbox"/> NC-SNAP Score _____	RESIDENCY <input type="checkbox"/> Private home with natural family <input type="checkbox"/> Individual Residence <input type="checkbox"/> Supervised Living _____ # of consumers <input type="checkbox"/> Group Home _____ # of consumers <input type="checkbox"/> Child Foster Care <input type="checkbox"/> AFL /Therapeutic Home <input type="checkbox"/> Other (Specify) _____
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CONTACT PERSON
<input type="checkbox"/> Next of Kin/ Relationship
<input type="checkbox"/> Legally Responsible Person
Type:
Date of Action:
Name: _____
Address: _____
City/State/Zip: _____
Phone (home): _____
Phone (work): _____

PARTICIPANTS IN PLAN DEVELOPMENT

NAME: _____

RECORD #: _____

Medical Information

Date Completed _____

	CODE	DIAGNOSIS	Indicate Primary Diagnosis with "P"
AXIS I	_____	_____	_____
	_____	_____	_____
AXIS II	_____	_____	_____
	_____	_____	_____
AXIS III	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
AXIS IV	_____	_____	_____
AXIS V	_____	_____	_____

MEDICATION	TARGET SYMPTOMS of THIS PERSON (Inc. Frequency, Intensity, Specificity)

ASSESSMENTS (Including Medical and Dental)	LAST DATE	APPROX. DUE DATE

NAME: _____

RECORD #: _____

What has happened in _____ life this past year (or if new plan, within the last few years)?
What goals have been met?

What does _____ want his/her life to be like? What is important? What are his/her goals?

NAME: _____

RECORD #: _____

Who am I? What is important to me? What are my strengths and preferences?

What would I change about my life? What are problems or needs that I may have? What is not working in my life?

What will we accomplish with this plan?

NAME: _____

RECORD #: _____

What support do I need to maintain what is important to me in my life, and to change the things noted above in my life?

What natural supports are available to me? Family, friends, co-workers, etc.?

What community supports are available to me? Church, community organizations, civic groups?

In addition to the above, what other supports may I need including public funded supports?

Are there needs in my life related to health and safety, such as identified medical issues, need for behavior or crisis plan? If so, how will they be addressed?

What is the process for obtaining back-up staff in case of emergency?

NAME: _____

RECORD #: _____

Action Plan

This actions plan is developed to help _____ meet his/her goals through addressing what needs to change and needs to be maintained as identified on the previous pages.

	DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #
METHOD OF EVALUATION:	

WHAT	How	WHO'S RESPONSIBLE	BY WHEN	SERVICE AND FREQUENCY

	DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #
METHOD OF EVALUATION:	

WHAT	How	WHO'S RESPONSIBLE	BY WHEN	SERVICE AND FREQUENCY

(Repeat page as necessary)

NAME: _____

RECORD #: _____

Case Management/Service Monitoring Plan

TYPE	FREQUENCY / CONTACT SCHEDULE
Face to Face: <div style="text-align: right; padding-right: 20px;">Individual</div> <div style="text-align: right; padding-right: 20px;">Family / Guardian</div> <div style="text-align: right; padding-right: 20px;">Provider(s)</div>	
Collaterals: <div style="text-align: right; padding-right: 20px;">Individual</div> <div style="text-align: right; padding-right: 20px;">Family / Guardian</div> <div style="text-align: right; padding-right: 20px;">Provider(s)</div> <div style="text-align: right; padding-right: 20px;">Education</div> <div style="text-align: right; padding-right: 20px;">Others (residential/ vocational, etc.)</div>	
<div style="text-align: right; padding-right: 20px;">Service Observations / Visits</div> <div style="text-align: right; padding-right: 20px;">Review of Service Documentation</div> <div style="text-align: right; padding-right: 20px;">Review of Outcomes/Supports Strategies</div> <div style="text-align: right; padding-right: 20px;">Review of CM Indicator on Medicaid Card</div>	
Other / Comments	

Attached are the following documents (check all that apply):

- | | | |
|--|--------------------------|--|
| NC-SNAP (required for new and renewal) | <input type="checkbox"/> | |
| Crisis Plan | <input type="checkbox"/> | |
| Behavior Plan | <input type="checkbox"/> | |
| Advanced Health/Mental Health Directive/DNR/PA | <input type="checkbox"/> | |
| Justification for Equipment or Supplies | <input type="checkbox"/> | |
| Individual Education Plan (IEP) | <input type="checkbox"/> | |
| Other (Explain) | <input type="checkbox"/> | |

NAME: _____

RECORD #: _____

Signatures

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services/supports to be provided.

- 1) I confirm/concur my involvement in the development of this assessment and plan of care. My signatures indicate concurrence with the services/supports to be provided.
- 2) I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded / Developmentally Disabled (CAP/MR-DD). I choose to participate in CAP/MR-DD.
- 3) I understand that I have the choice of service providers and case managers and may change at anytime by contacting my case manager.

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Case Manager: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

NAME: _____

RECORD #: _____

Plan Update/Revision

Implementation Date: _____

What has happened in _____'s life (personal or clinical) to cause the need for revision?
(Attach update NC-SNAP if there are changes)

Based on what is happening in my life, what is important to me now? What are my strengths and preferences?

Based on what is happening in my life, what needs to change now? What new problems or needs do I have? What is not working in my life?

What do we need to know or do to support _____ differently?

_____ DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #

WHAT	HOW	WHO'S RESPONSIBLE	BY WHEN	SERVICE & FREQUENCY

Required Signatures: The following confirms the involvement of the individual / guardian in the update of this plan including revision to the cost summary.

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Case Manager _____ Date: _____

_____ Date: _____